

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-044718

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 229

Primary Registration District No. 5763

Registrar's No. 40

FILED NOV 18 1963

VS 300
Rev. 4/59

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK
OR
TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY <u>Marion</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Marion</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Union Township</u>		c. CITY OR TOWN <u>RFD I - Philadelphia, Mo.</u>	
Length of stay in 1b <u>3 years</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>RFD I - Philadelphia, Mo.</u>		d. STREET ADDRESS (If outside, give location) <u>Union Township</u>	
Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Banks</u> Middle <u>Gerald</u> Last <u>Ferguson</u>		4. DATE OF DEATH Month <u>Nov</u> Day <u>4</u> Year <u>1963</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>9 Feb. 1909</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>	9. AGE (last birthday) <u>54</u>
11. BIRTHPLACE (City and state or country) <u>Custer City, Okla.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>James S. Ferguson</u>		13b. MOTHER'S MAIDEN NAME <u>Fannie Banks</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>666</u>	
17. INFORMANT <u>Ms Wynona Shipman</u>		Address <u>Box 3</u> <u>Imperial, Calif.</u>	
18. CAUSE OF DEATH (Enter only one cause per PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gunshot wound of brain</u>		INTERVAL BETWEEN ONSET AND DEATH <u>few minutes</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Complained of severe abdominal pain 1 hr. before</u>		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20. ACCIDENT <input type="checkbox"/> SUICIDE <input checked="" type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour <u>6</u> Minute <u>00</u> Month, Day, Year <u>11 4 63</u>	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY _____ STATE _____	
21. I attended the deceased from _____, to _____ and last saw her/him alive on _____ Death occurred at <u>6:00 pm</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Henry Sweet Jr. M.D. Coroner</u>		22b. ADDRESS <u>1 Sanmbae</u>	
22c. DATE SIGNED <u>11/5/63</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>11-6-63</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Thomas, OKLA.</u>	
24. FUNERAL DIRECTOR <u>Lewis Bros. Palmyra, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>11-6-63</u>	
26. REGISTRAR'S SIGNATURE <u>Dr. E. M. Lucke</u>		By <u>Viola Geer, Deputy</u>	

(Licensed Embalmer's Statement on Reverse Side)

JAN 3 1964

DEC 4 1963

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed

J B Lewis

Licensed Embalmer No.

4875

P. O. Address

Palmyra, MD

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.